The Conservative Case for Universal Coverage

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Conservative vs. Progressive Policy Priorities

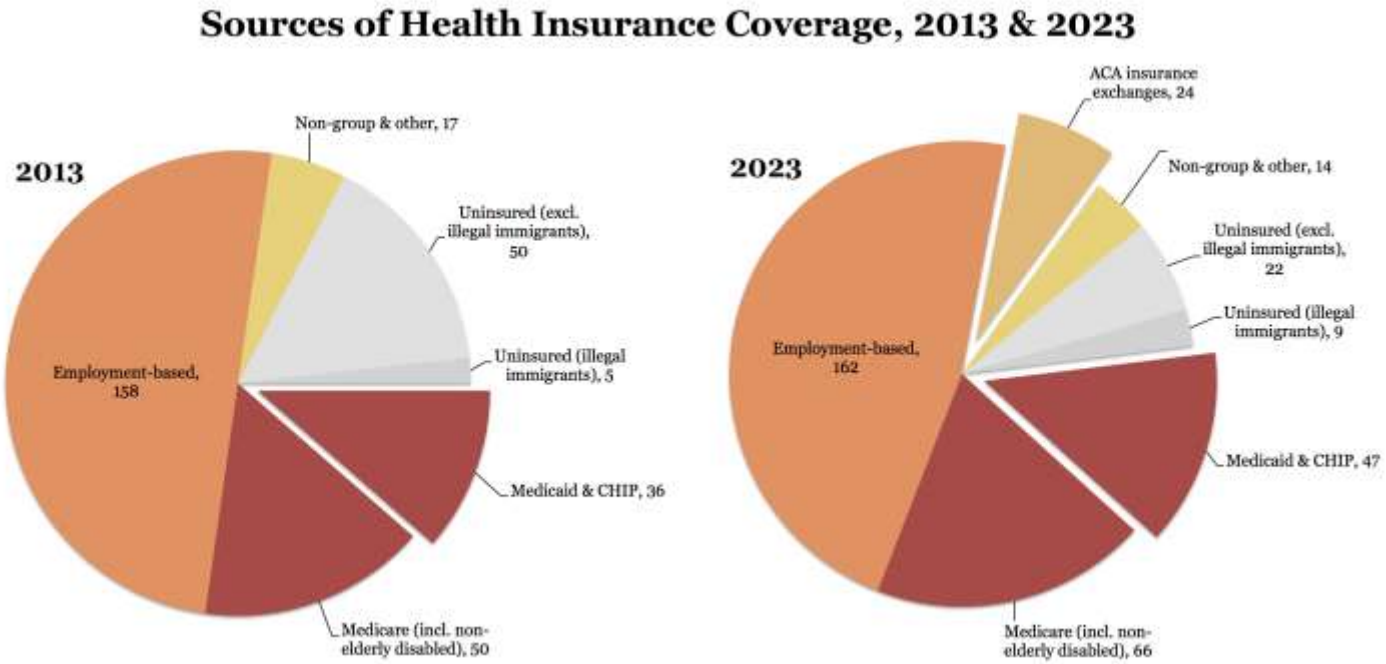
- The left has long fought for universal coverage
  - Health care is a core component of economic equality
  - Every other developed country has universal coverage
- The right has fought for limited government
  - Conservatives seek to reduce government spending
  - Long wait times, poor access in single-payer systems
  - Broad satisfaction with existing arrangements
    - 88% of Americans with insurance like their plans
    - Conservatism: "if it ain't broke, don't fix it"
  - Perception that American system is "free-market"

U.S. System is Mix of Private & Single Payer

- The U.S., in reality has not one, but *six* distinct health-care systems:
  - **Private**, **tax-subsidized**, employer-sponsored insurance (158MM Americans in 2013, 162MM in 2023, CBO projects)
  - **Private**, unsubsidized, individually-purchased health insurance and other (17MM in 2013, 14MM in 2023)
  - Medicare, a **government-run** single-payer system for the elderly (50MM in 2013, 66MM in 2023)
  - Medicaid and CHIP, **government-run** single-payer systems for poor Americans (36MM in 2013, 47MM in 2023)
  - ACA exchanges, **government-subsidized private insurance** for lower- and middle-income Americans (0 in 2013, 24MM in 2023)
  - Uninsured/self-pay, eligible for **government-mandated** emergency care (55MM in 2013, 31MM in 2023)

U.S. System is Mix of Private & Single Payer

- Between 2013 and 2023, state-run insurance will expand (27% → 33%), but so will individually-purchased coverage (5% → 11%)



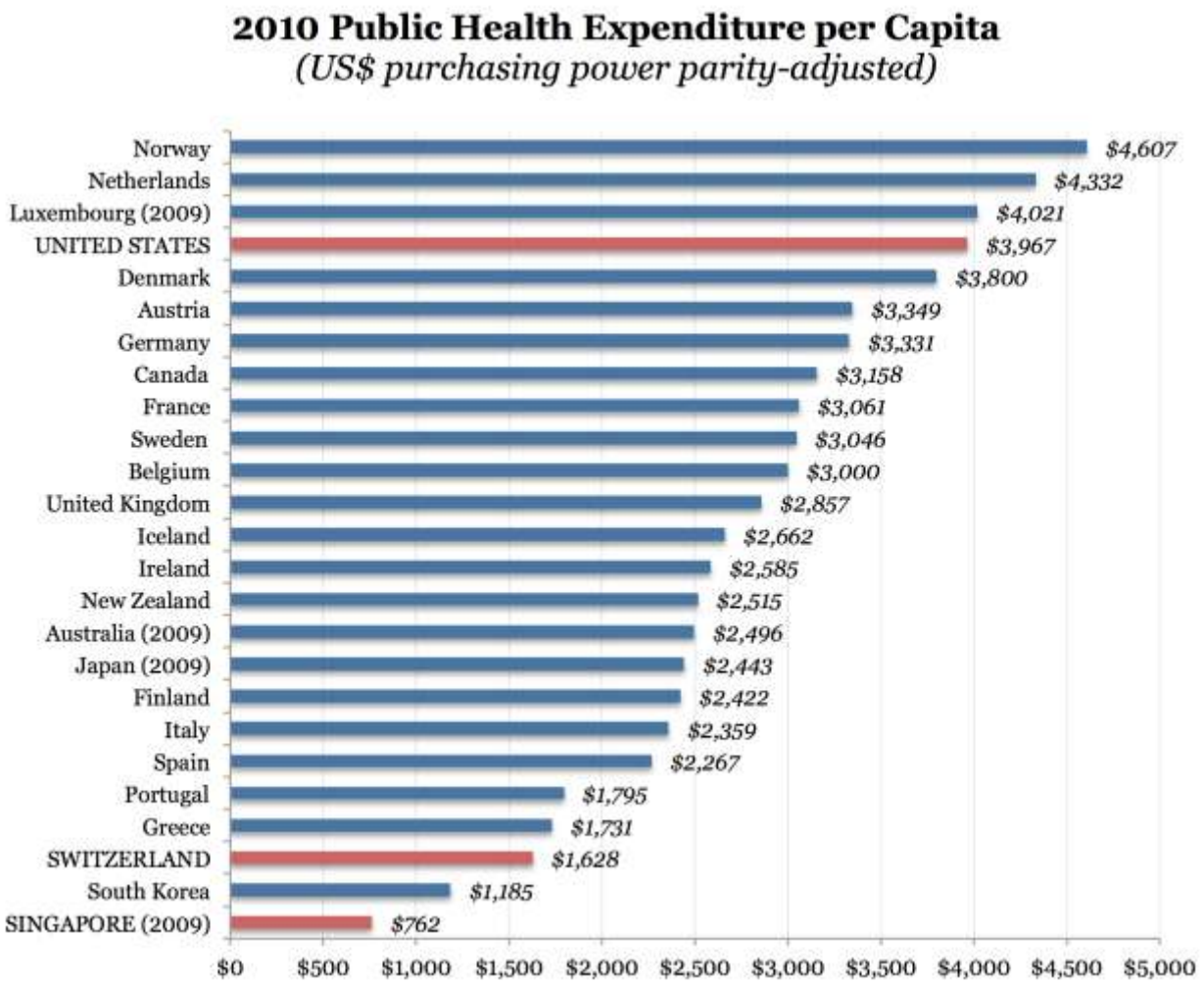
Who Gets Subsidized Health Care? You

- The vast majority of Americans receive federally subsidized health insurance
  - Medicare (everyone over 65, certain disabled people)
    - $600 billion a year
  - Medicaid (pre-ACA, certain poor people)
    - $450 billion a year
  - ACA (everyone below 400% of the federal poverty level)
    - $200 billion a year (when fully implemented)
  - **People with insurance through their employers**
    - $300 billion a year

Reforming the Employer-Sponsored System

- Today, if you get insurance through your employer, you don't pay income or payroll taxes on that spending
  - Workers don't get to choose their own plans
  - Plans are more generous than workers need, driving costs up
  - Workers can't keep their insurance if they change or lose jobs
  - Unlimited deduction subsidizes the wealthy
  - Deduction is unavailable to the self-employed or unemployed
  - Resultant health inflation harms wage growth
- **It's easy to waste other people's money!**

The Myth of 'Free-Market' U.S. Health Care

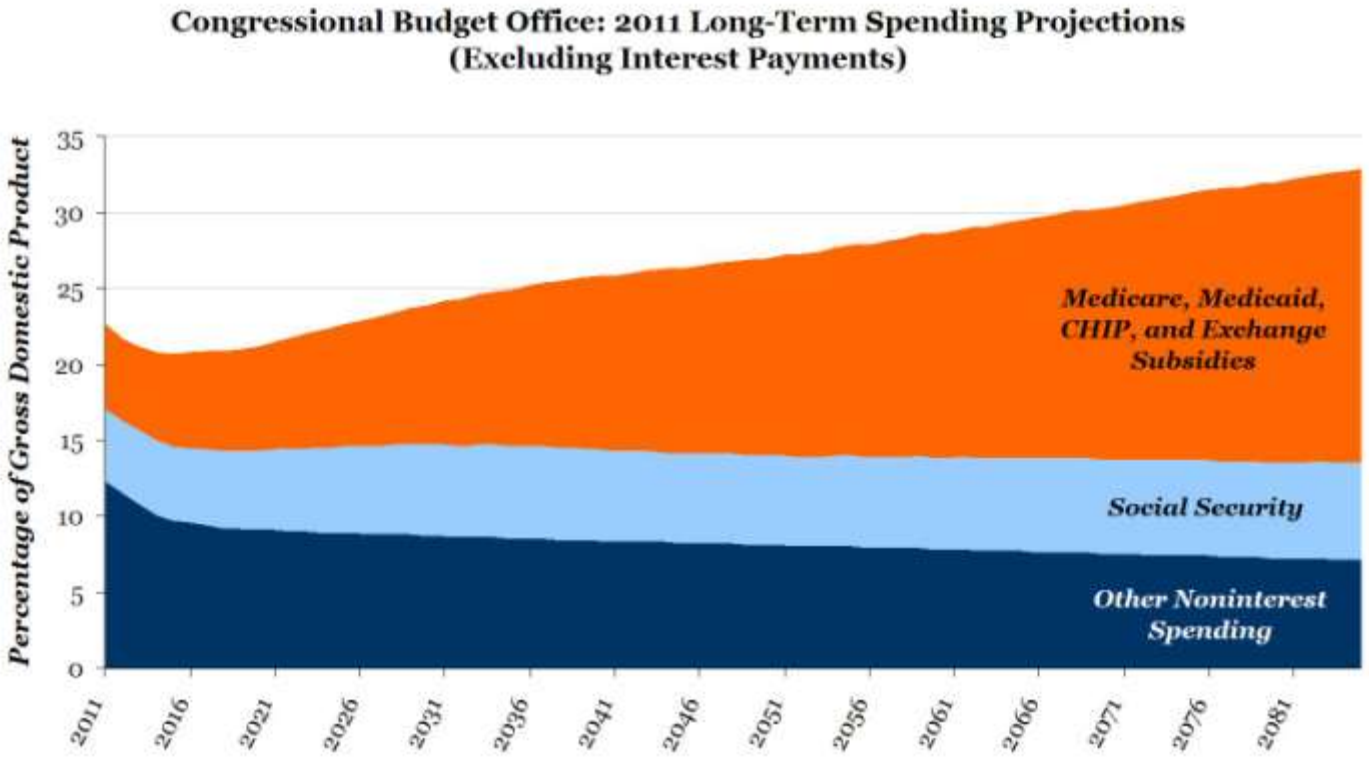


Source: OECD, WHO

- In 2010, U.S. government (federal, state, local) **spent more per person on health care** than all but two other countries in the world
- Post-ACA, U.S will likely become #1

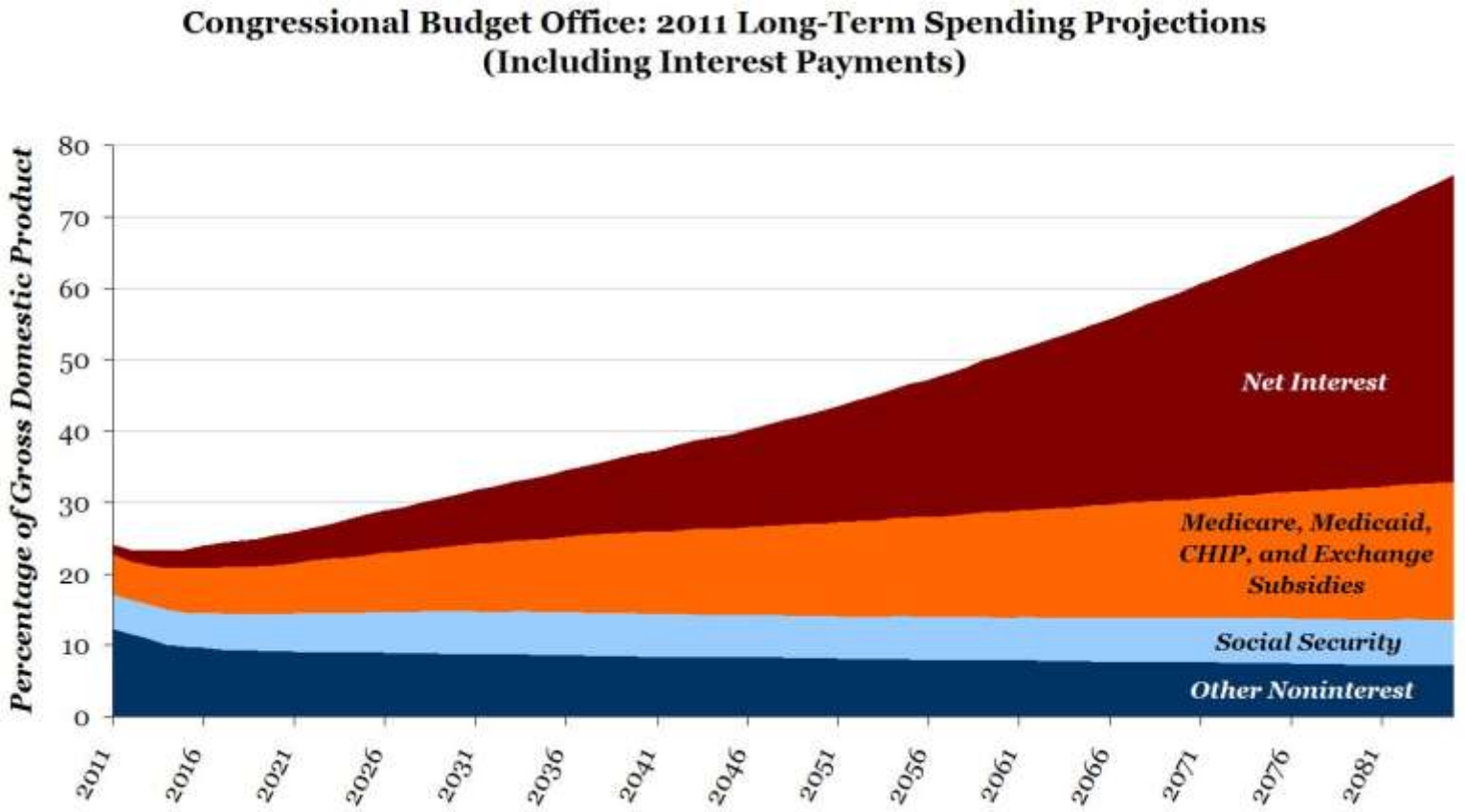
Half of U.S. Health Spending is Government

- The entirety of the growth of government spending as a share of GDP is health care…



Half of U.S. Health Spending is Government

- …If you don't count interest on the debt



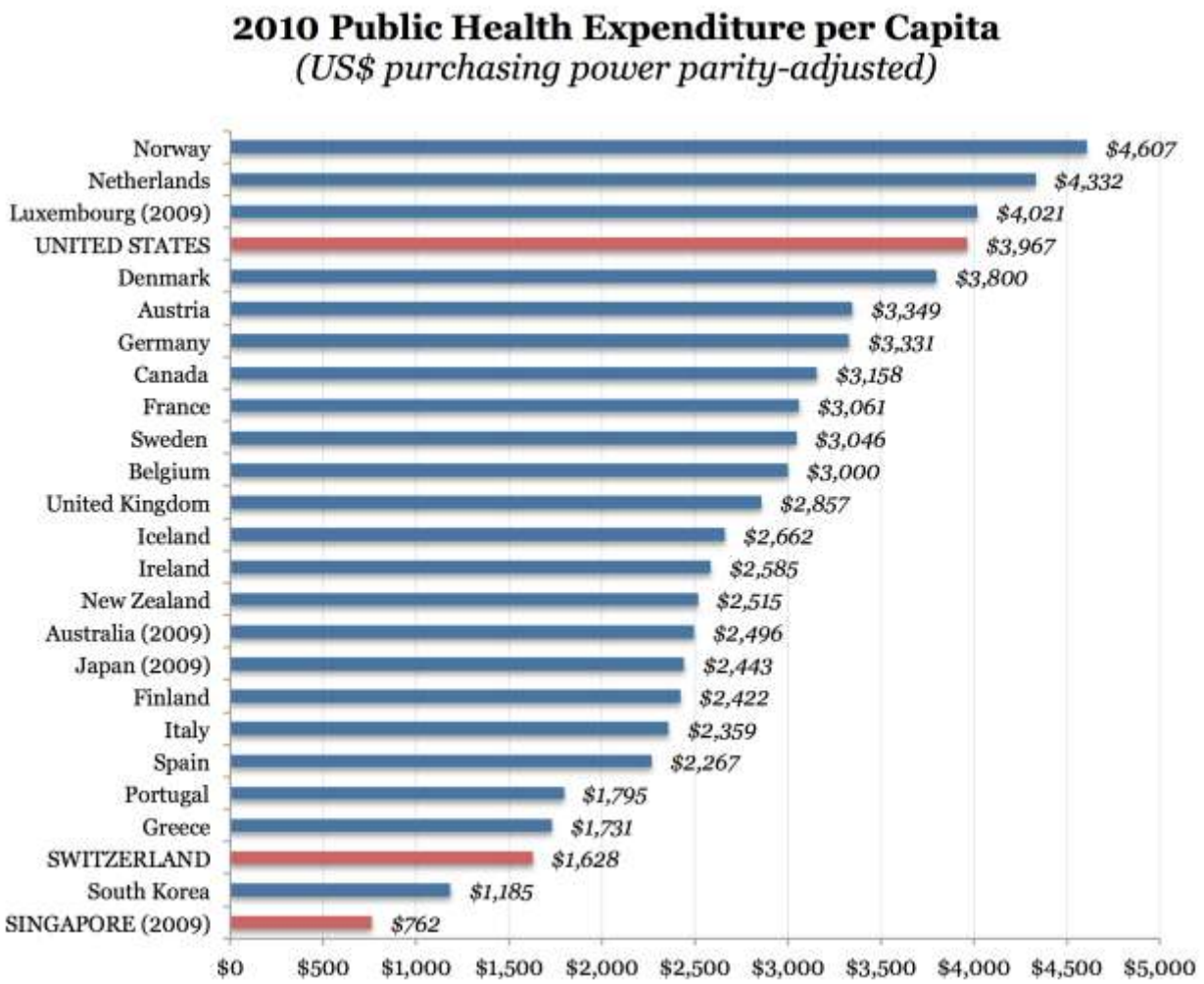
How Market-Oriented is the U.S. vs. Others?

- Some developed nations are less market-oriented than the U.S.:
  - **United Kingdom**: Socialized system in which government owns the hospitals, employs the doctors, and pays the bills
- Some are about equally market-oriented:
  - **France**: Government sponsors basic universal coverage, but allows people to buy supplemental, largely unregulated private insurance; private providers
- Some are *more* market-oriented

How Market-Oriented is the U.S. vs. Others?

- Universal coverage can be market-oriented
  - **Switzerland**: "Premium support" system in which government subsidizes private insurance for all, with moderate flexibility in insurance plan design; similar to Massachusetts Health Connector, ACA exchanges, and Paul Ryan Medicare reforms
  - **Singapore**: Universal, single-payer catastrophic coverage combined with universal health savings accounts (HSAs) and cash-paying for non-emergency care

The Myth of 'Free-Market' U.S. Health Care



Source: OECD, WHO

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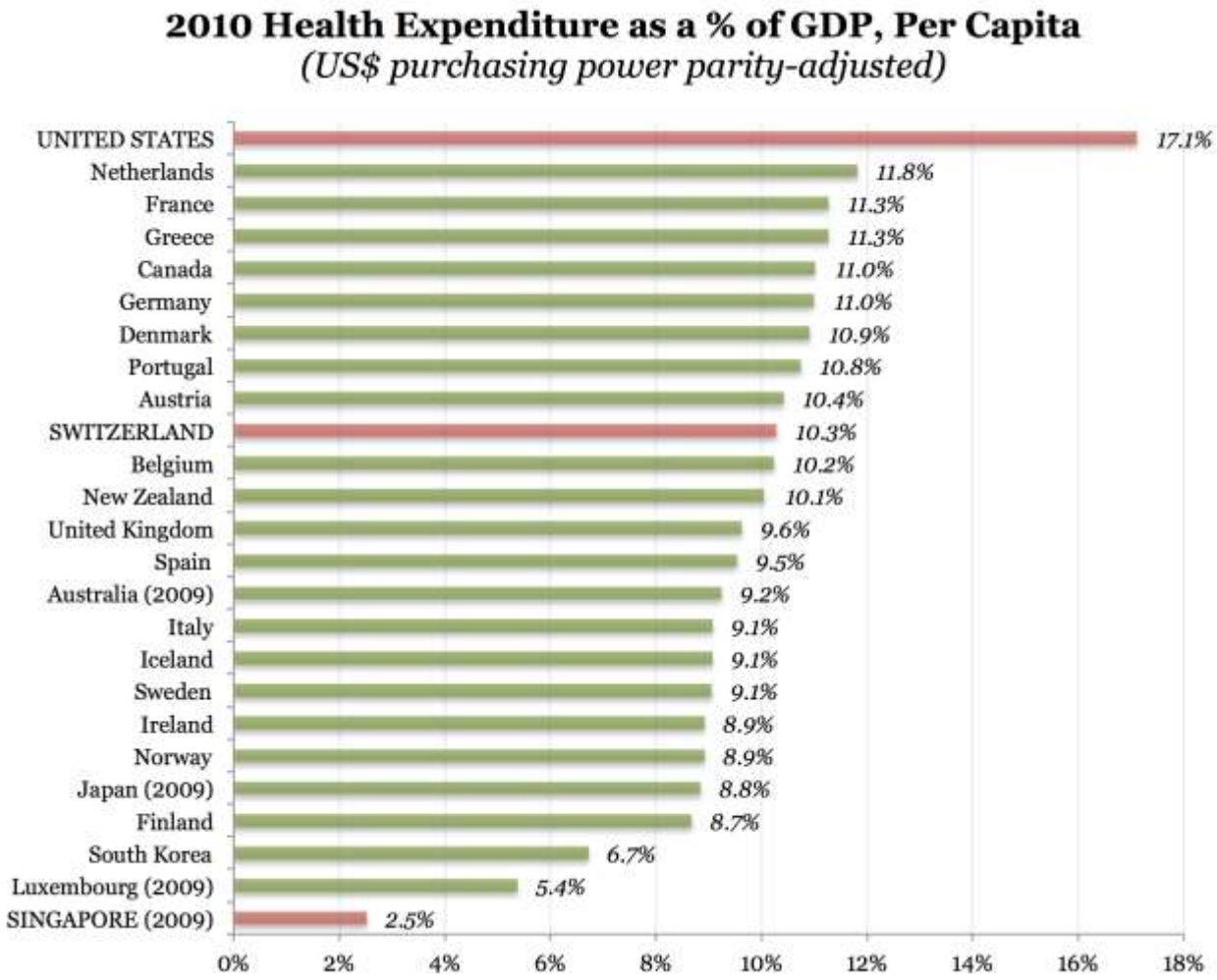
Real Market-Based Health Care Spends Less



Source: OECD, WHO

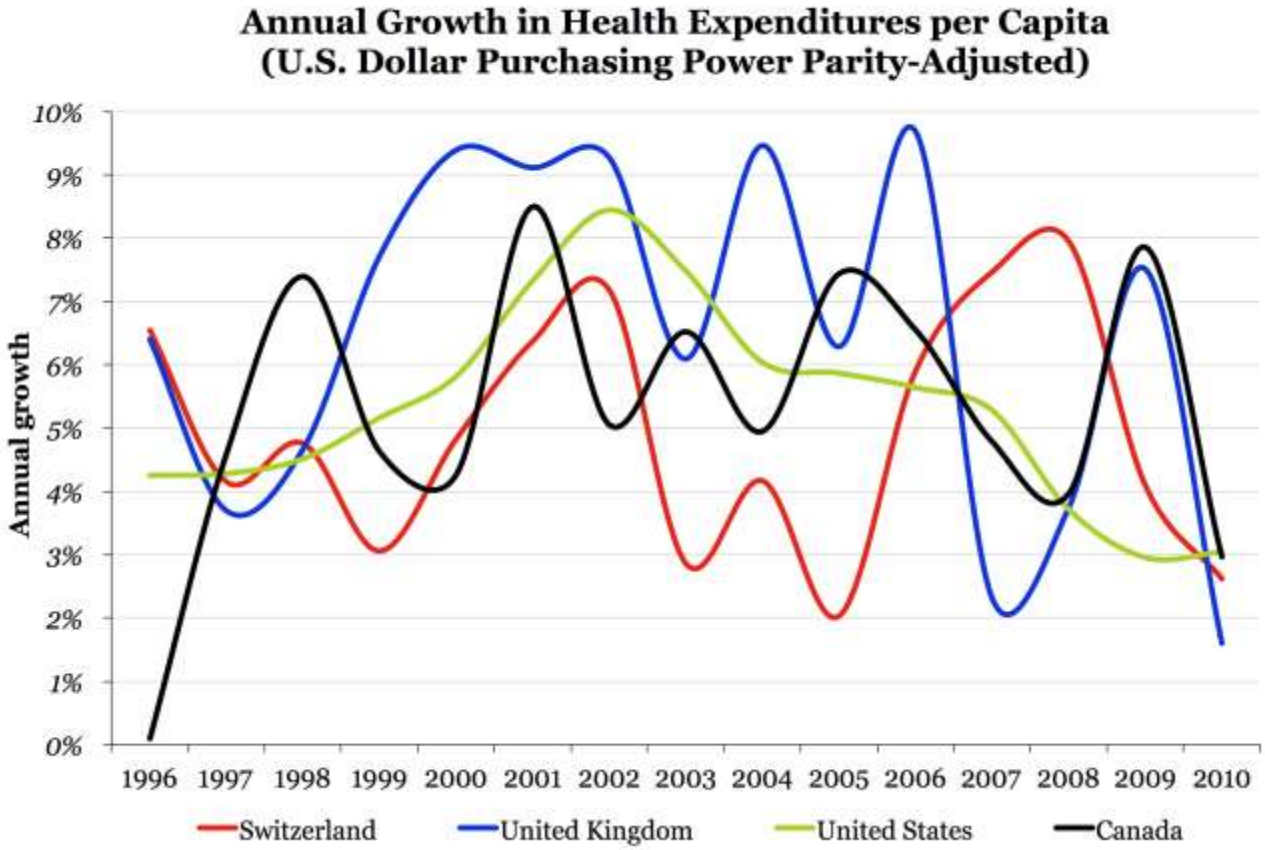
- Singapore spends 2.5% of per-capita GDP on health care, vs. U.S. 17.1%
- Switzerland (10.3%) within mainstream of EU; less than Canada, France, Germany
- **Market-oriented health systems perform well**

Bottom Line: Cost Control Starts at Home!

- Direct payment for health care reduces costs…
  - Individuals directly control their own spending, leading to less of it (cash bar vs. open bar)
  - Maximum provider incentives for quality, customer service, and innovation (e.g. LASIK surgery)
  - Maximum financial and personal flexibility and choice
- …Unless you think Americans are too dumb
  - Patients may not make wise or informed decisions
  - Direct payment could lead lower-income individuals to forego useful and/or necessary care
    - Insurance plan design can accommodate this concern

U.S. Health Spending Growth is Not Atypical

Source: OECD, WHO



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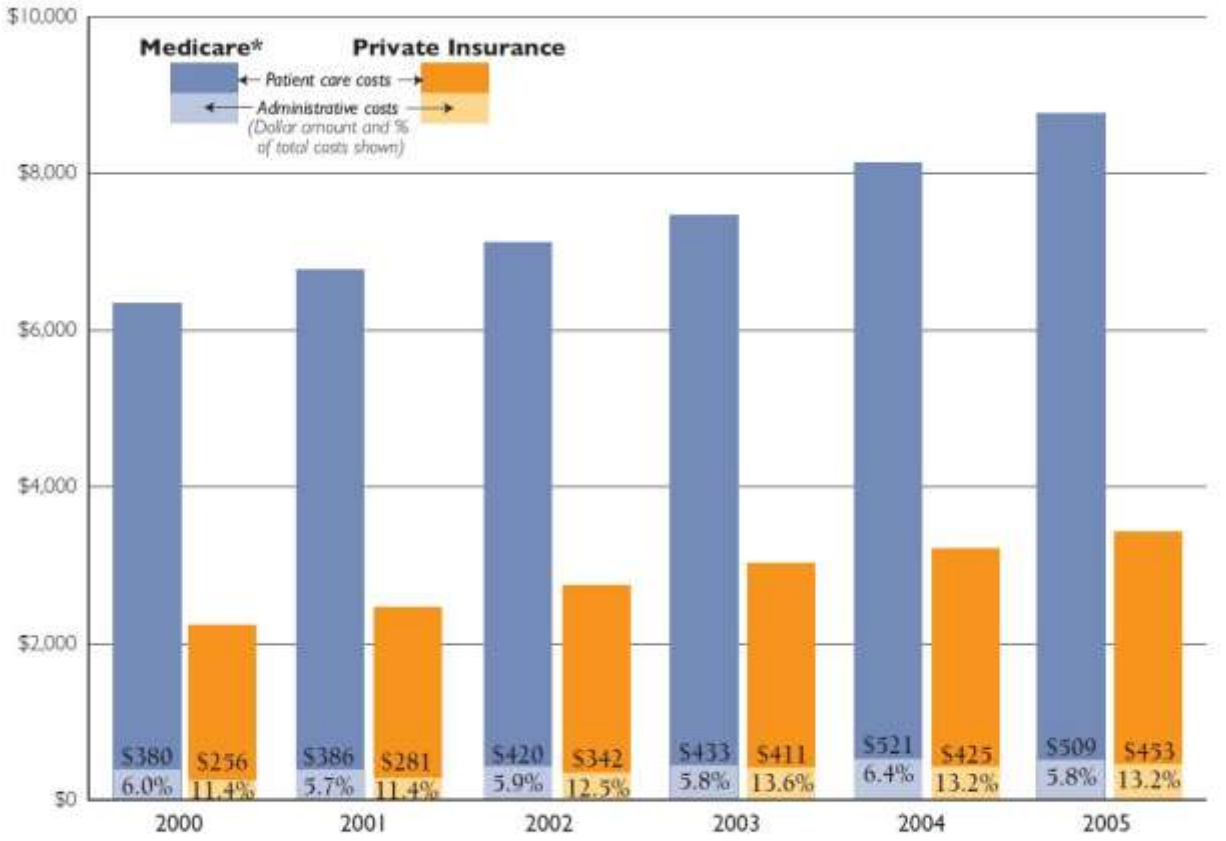
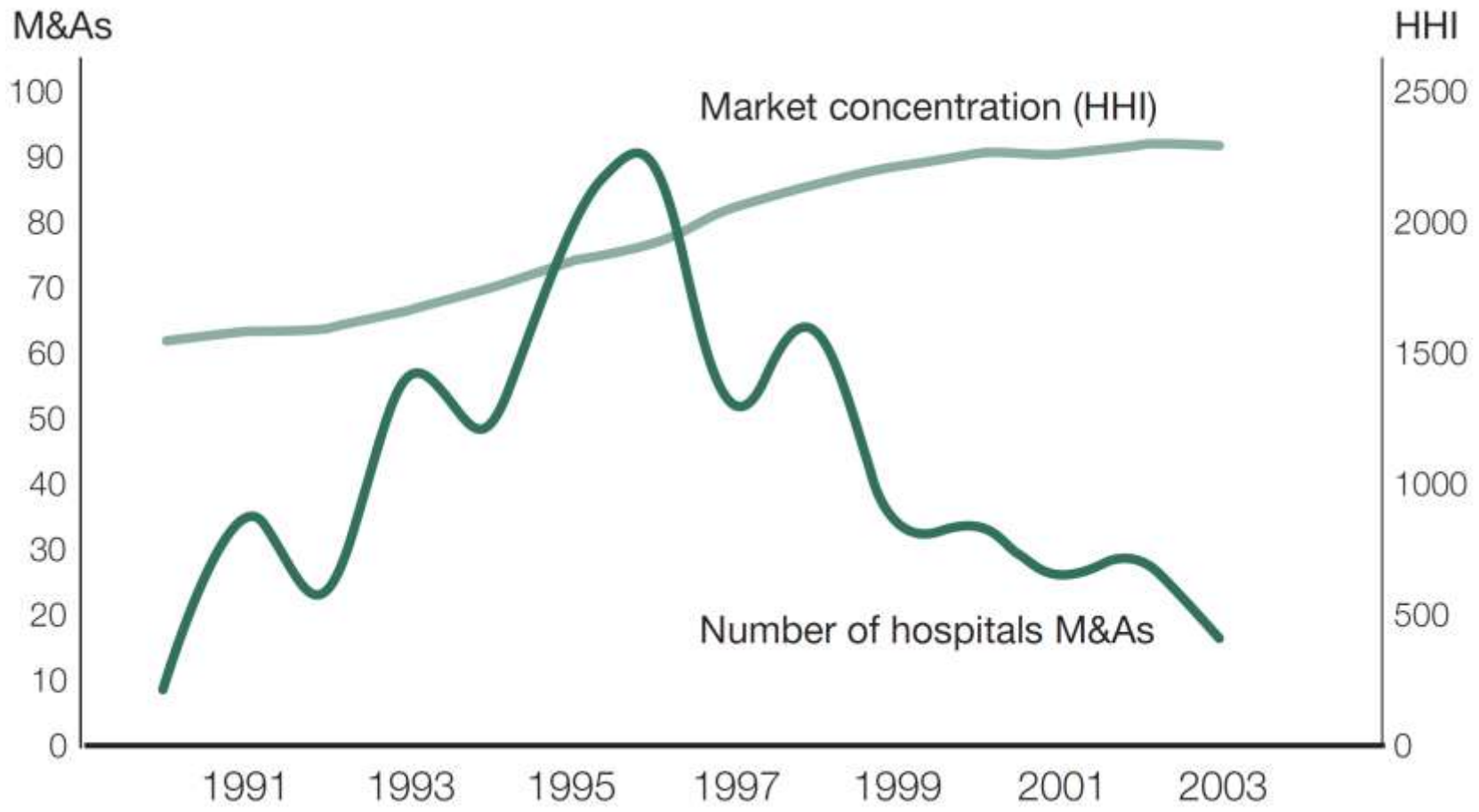
Single Payer Isn't As Efficient As It Looks

- In 2005, Medicare's *per-beneficiary* administrative costs were $509, vs. $453 for private insurance
- Conventional discussion of administrative costs ignores higher denominator



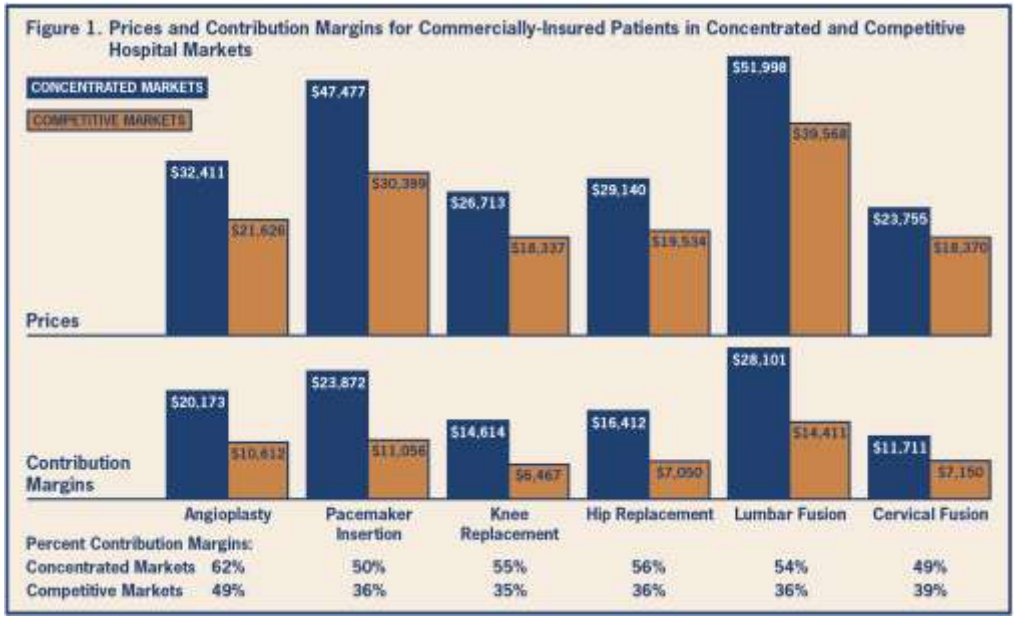
Hospital Monopolies: The Evil Empire

Source: Vogt and Town, 2006; American Hospital Association



Concentration Increases Hospital Profits

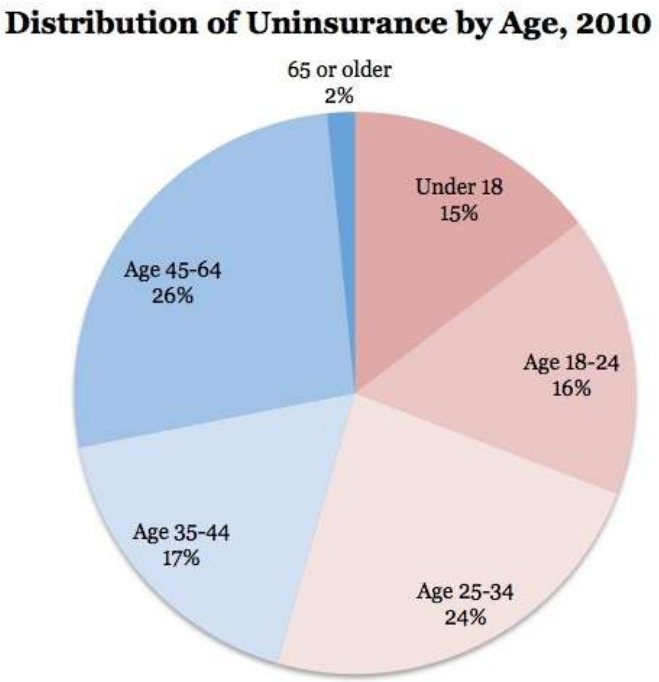
- Robinson (2011) compared prices for procedures in consolidated vs. competitive hospital markets
  - Procedures cost 44% more in consolidated markets
  - Nearly all profit: margins in consolidated markets 41% higher

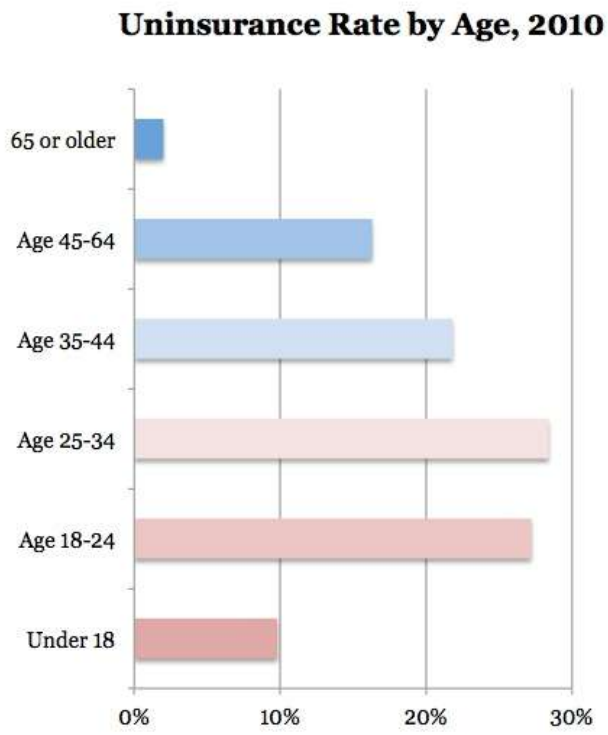


The "Affordable" Care Act?

Who Are the Uninsured?

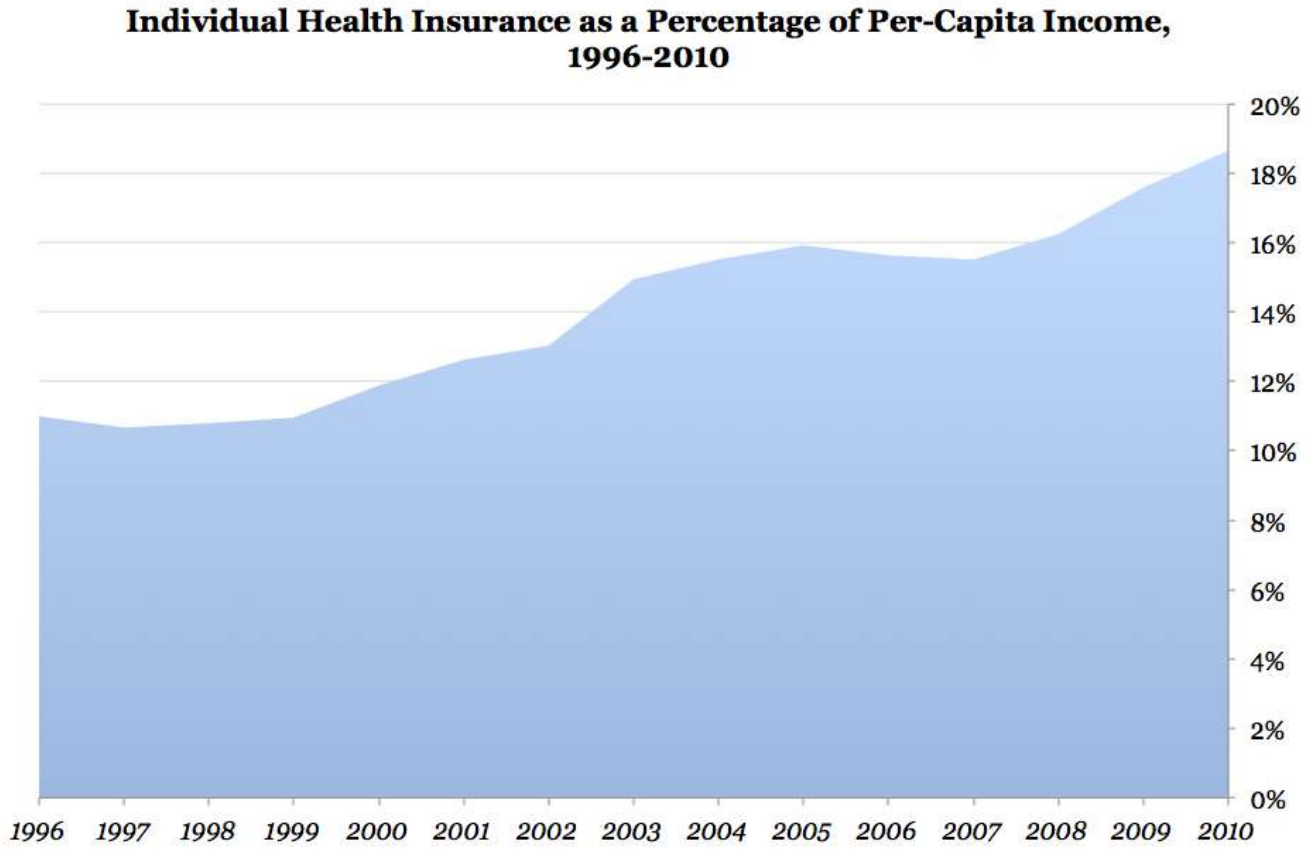
- The uninsured are primarily young and healthy





Who Are the Uninsured?

- Cost is a huge problem

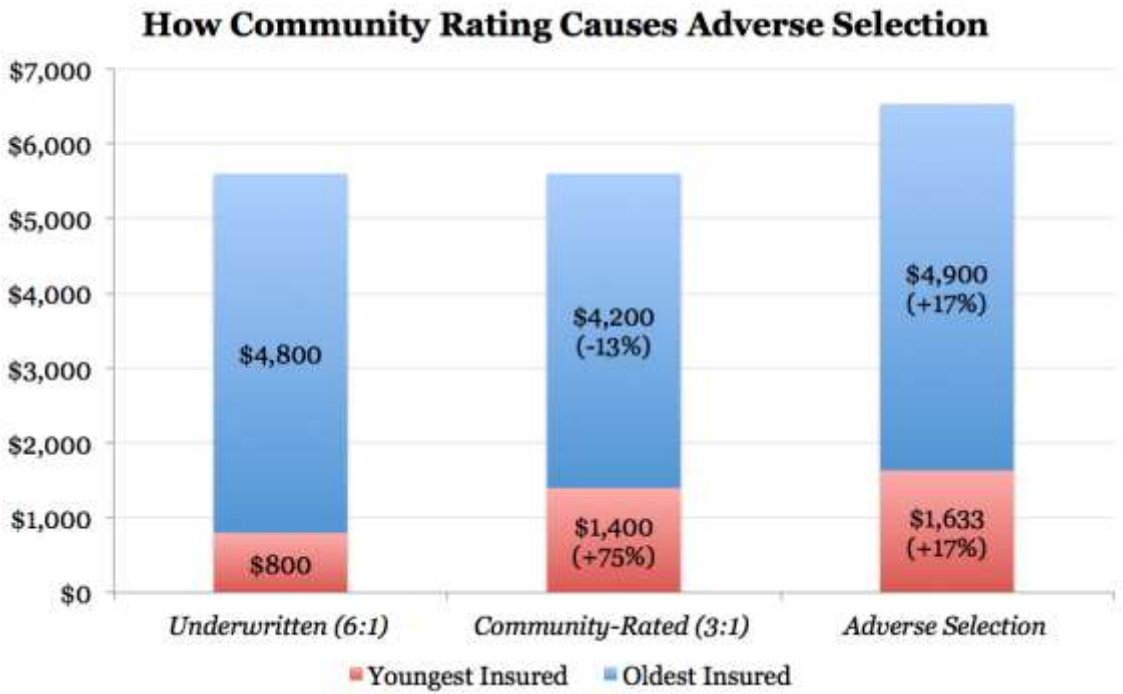


Rate Shock in the Individual Market

- The ACA dramatically increases the cost of individually-purchased health insurance, by:
  - Requiring young people to subsidize older people
  - Requiring all insurers to cover those with pre-existing conditions, and prohibiting different rates based on gender and health status
  - Requiring all plans to cover specified health benefits
  - Taxing health premiums, drugs, and medical devices
  - **Barring insurance plans with high deductibles and co-pays (minimum actuarial value)**

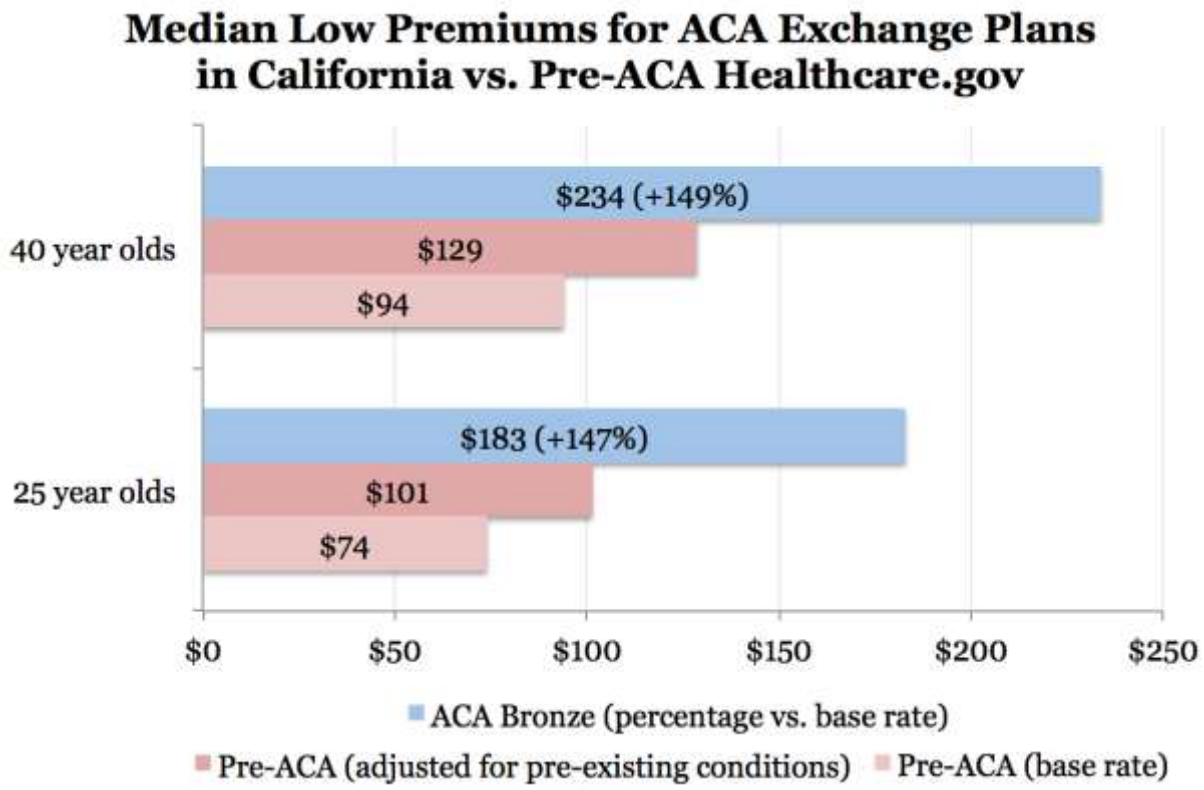
The ACA Increases Premiums for the Young

- The ACA's individual mandate is weak, which will cause adverse selection
  - For many, mandate fine ($695) much cheaper than insurance ($6,000)
  - Community rating will increase insurance costs for young in order to subsidize the middle-aged, further encouraging the young to drop out



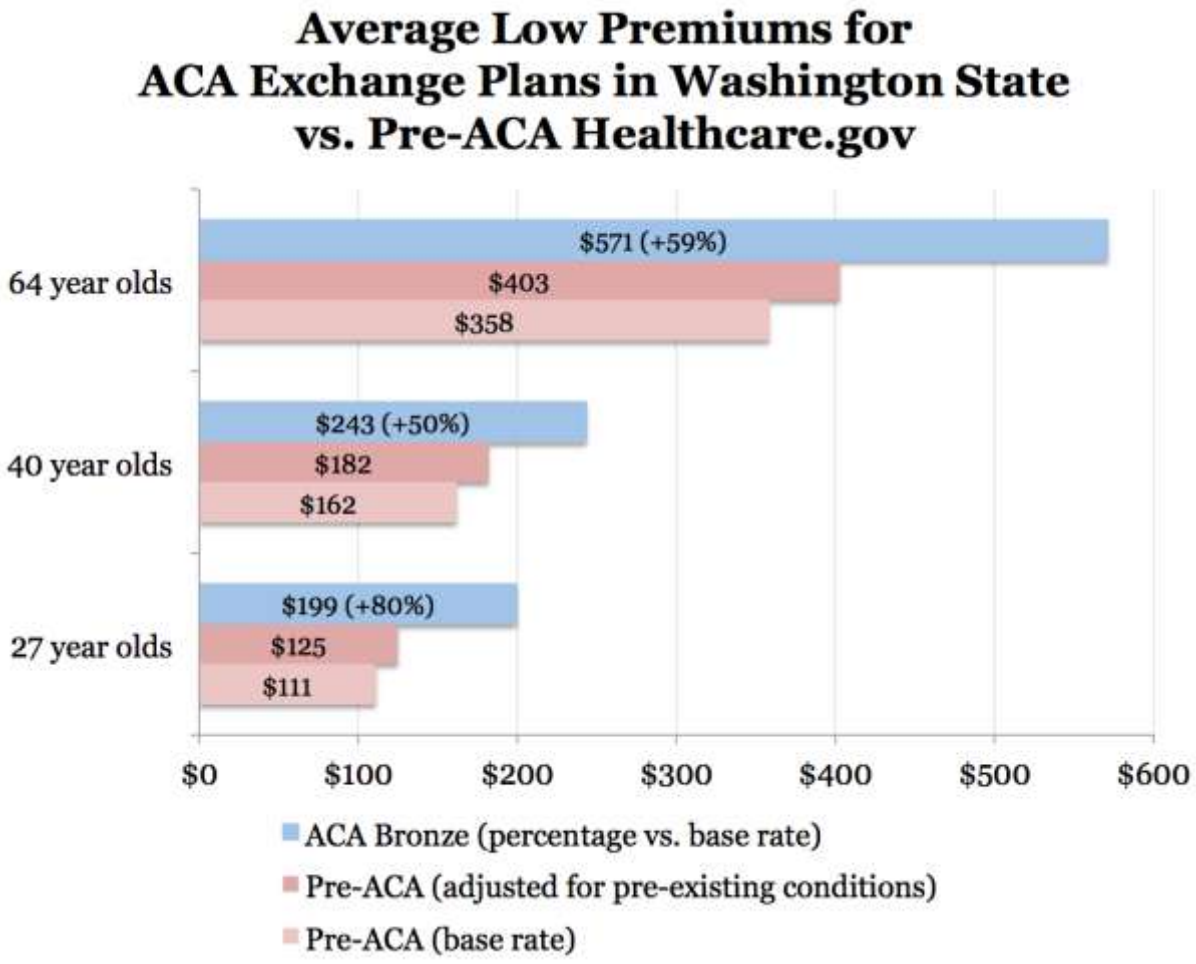
Rate Shock Highest In Less-Regulated States

- Rate shock will be greatest in states with lightly-regulated insurance markets, like California (+147-149% pre-subsidies)



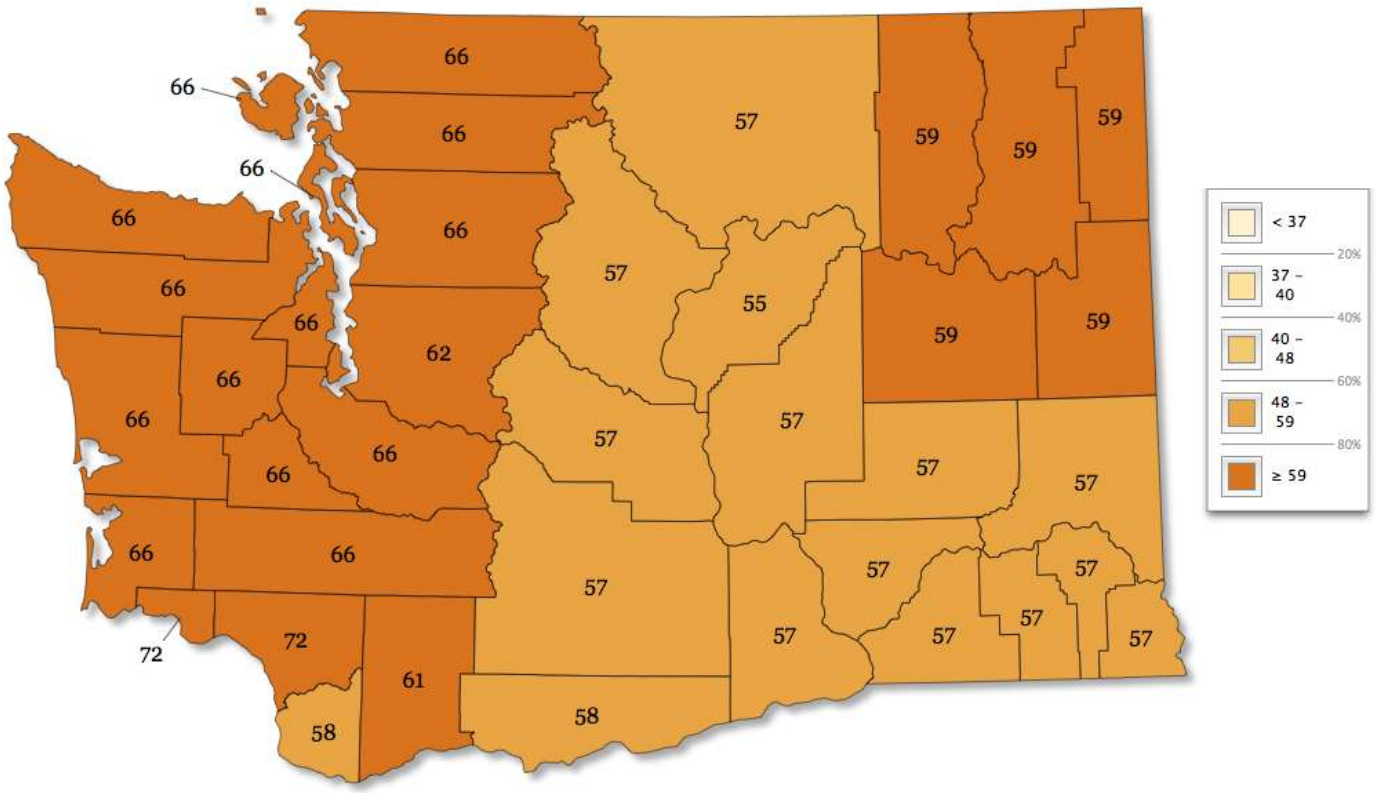
Even High-Regulation States Face Hikes

- Rate shock will be less, but still significant, in states like Washington with heavily regulated insurance markets (+50-80% pre-subsidies)



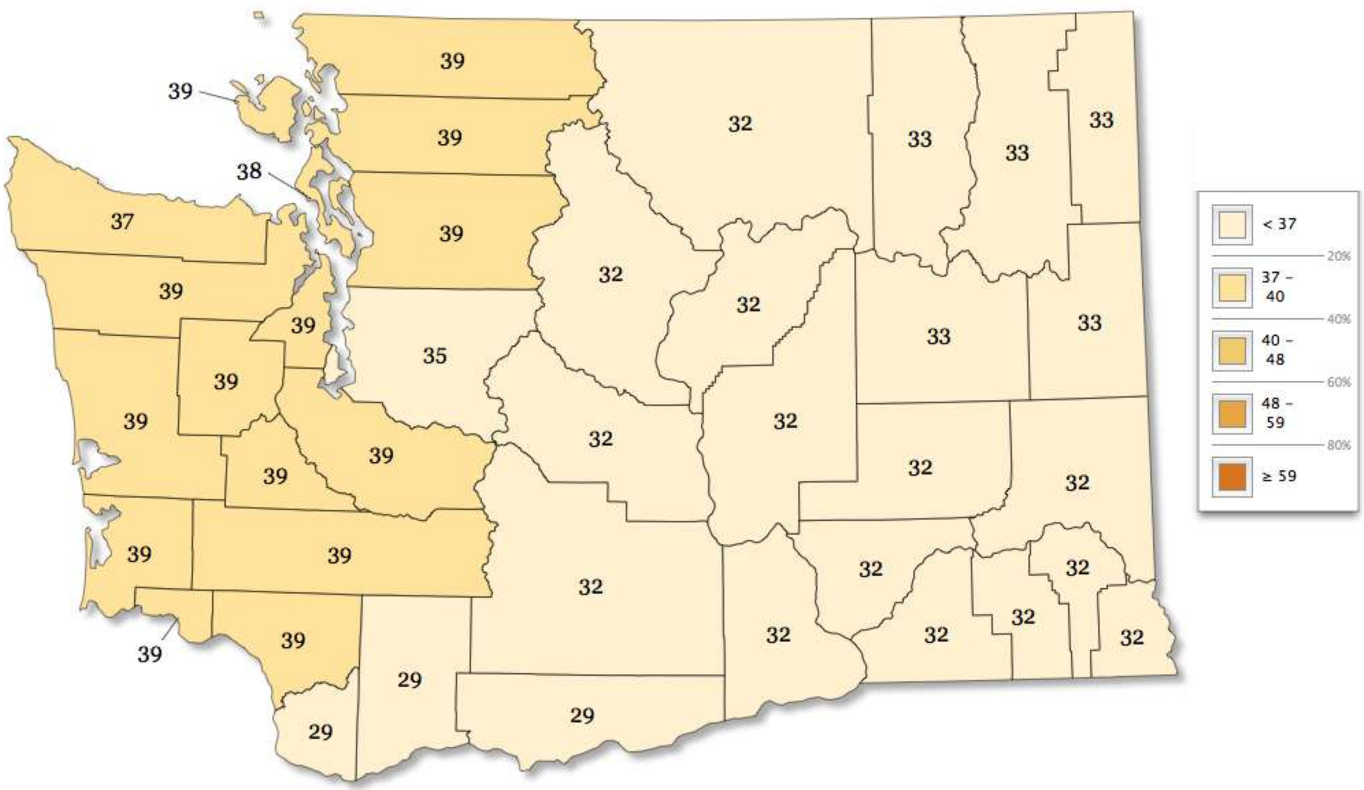
Western Washington State Most Affected

ACA Bronze Premiums vs. Pre-ACA Healthcare.gov for a 27-Year-Old Non-Smoker in Washington, Adjusted for Pre-Existing Conditions (Percent Increase in Price)



Western Washington State Most Affected

ACA Bronze Premiums vs. Pre-ACA Healthcare.gov for a 40-Year-Old Non-Smoker in Washington, Adjusted for Pre-Existing Conditions (Percent Increase in Price)



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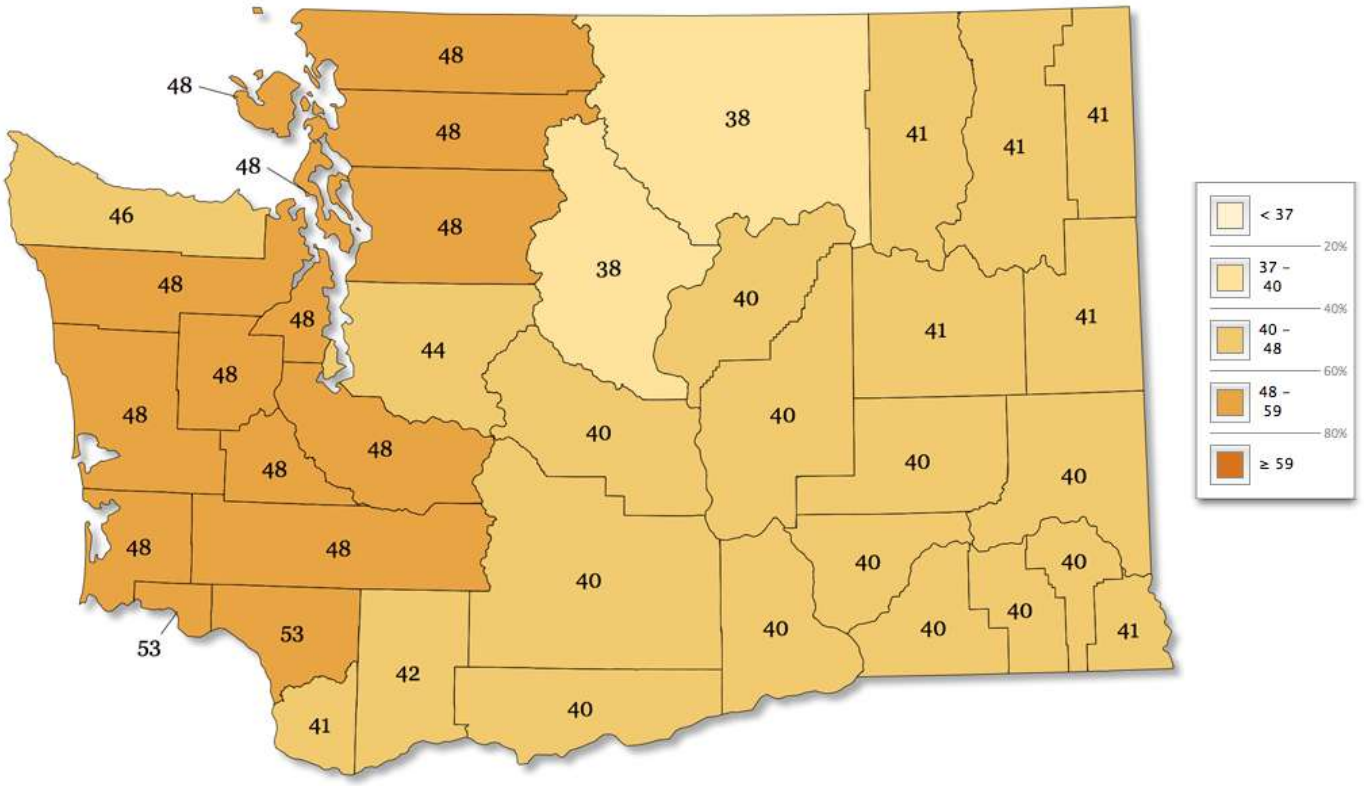
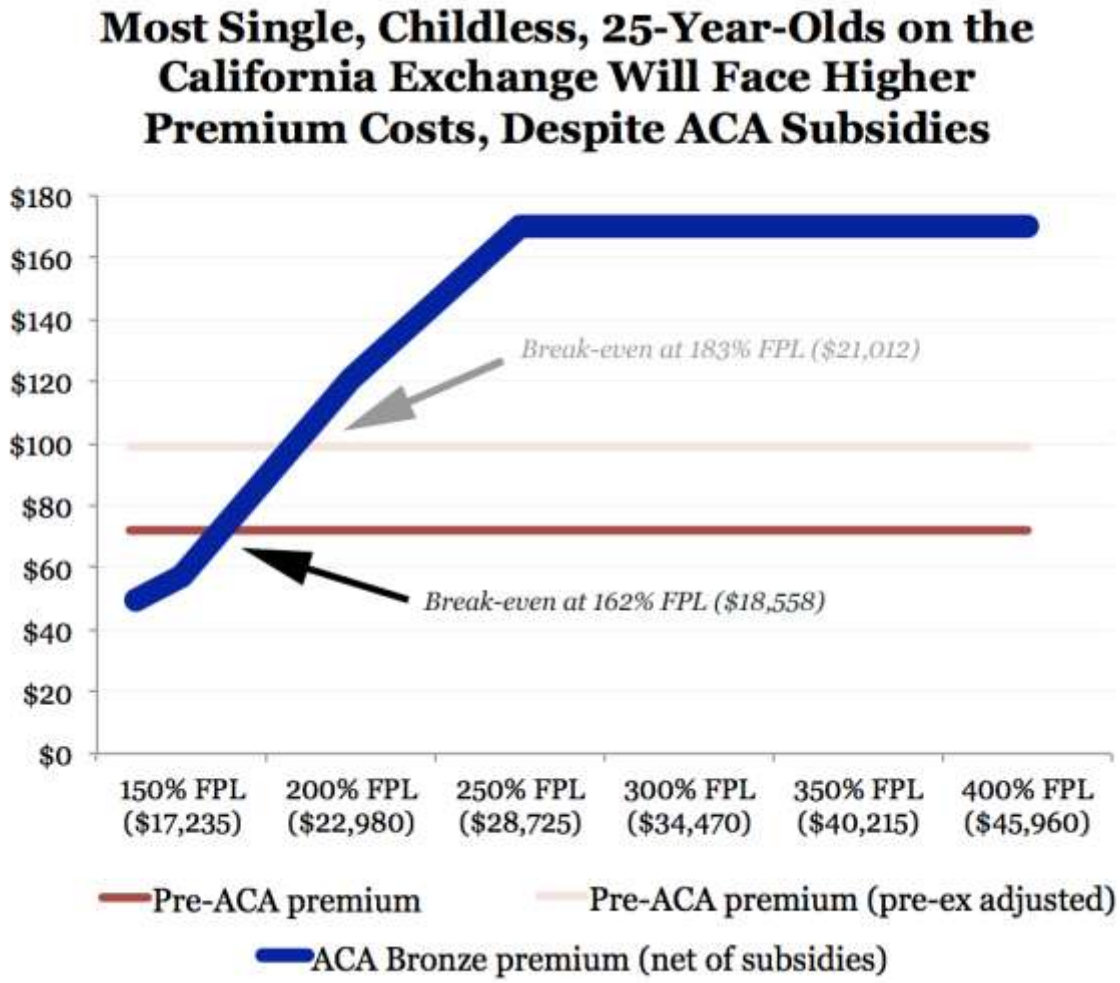


Subsidies Don't Make Up For Rate Shock



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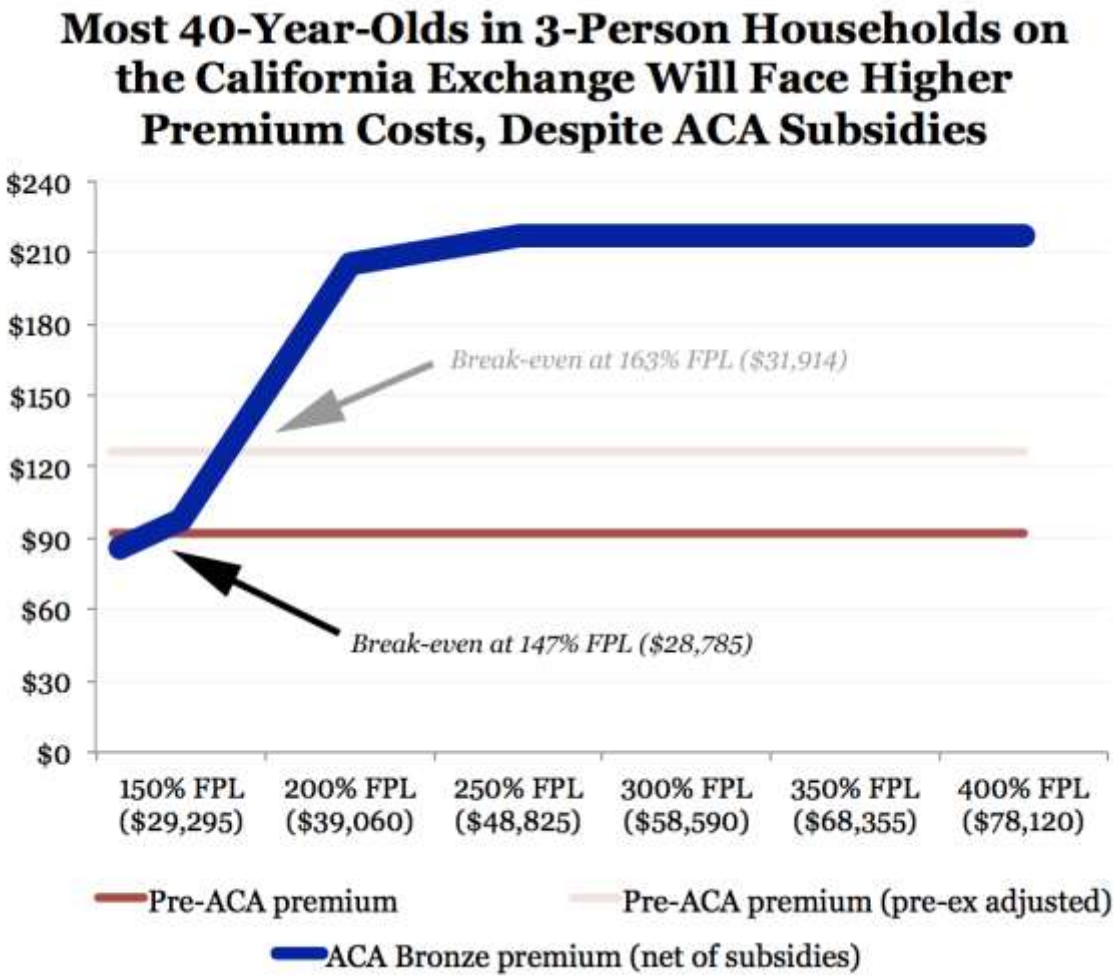
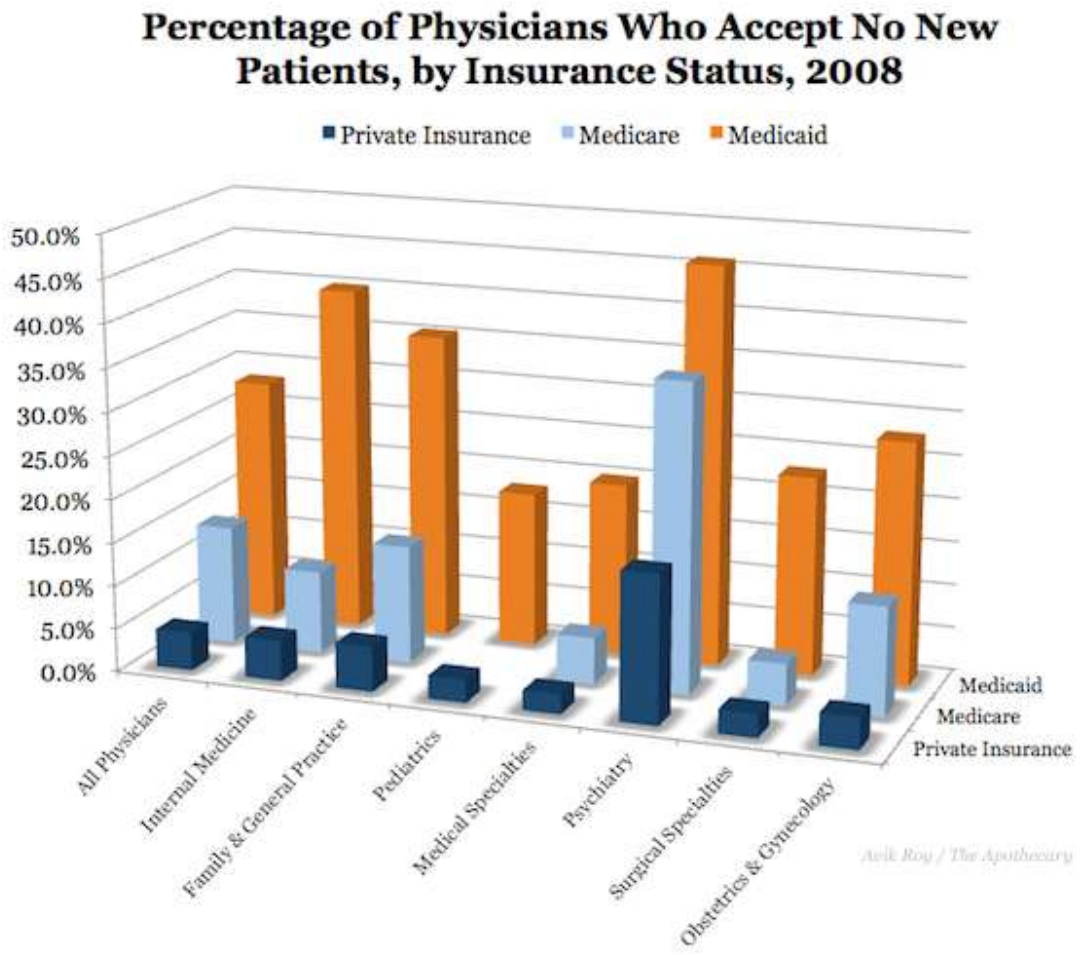


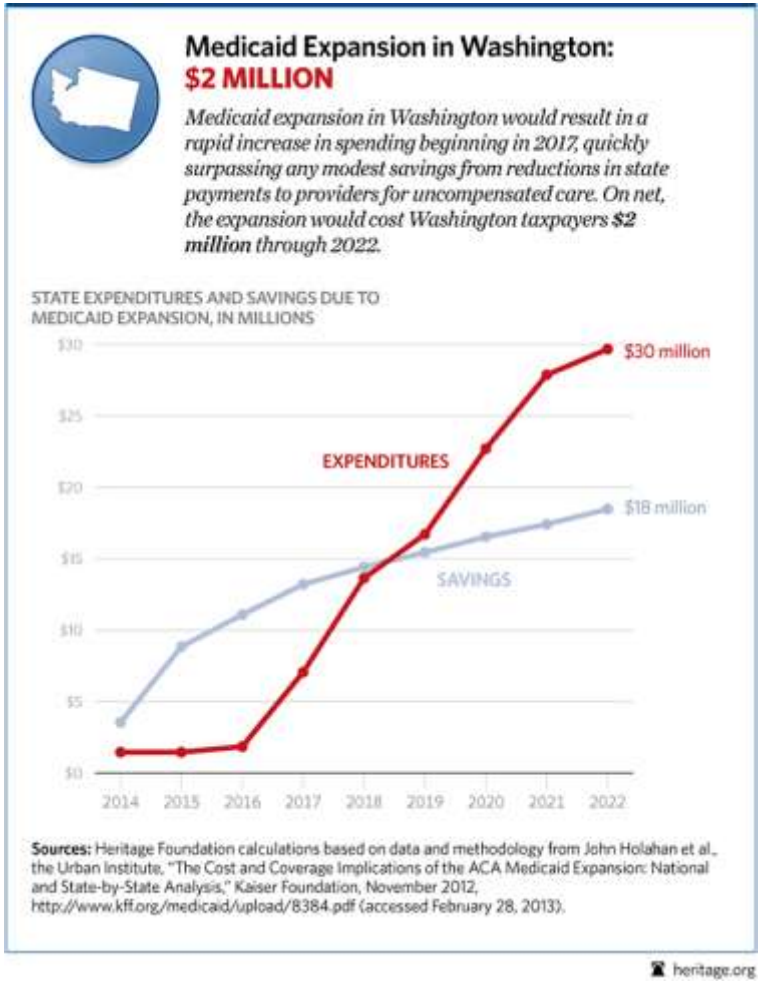
Health Insurance ≠ Health Care

- The ACA expands Medicaid, but the quality of that coverage is poor
- Medicaid and CHIP expansions, accounting for 11 million new insured, underpay physicians, resulting in poor access
- 7 million Americans will lose higher-quality private coverage



Medicaid Expansion Ups Taxpayer Liabilities

- While Washington will receive significant federal funding to expand its Medicaid program, the state will spend more than $12 million a year in additional funds, starting in 2022
- Oregon Medicaid experiment found no improvement in health outcomes vs. uninsured



ACA's Medicare Reforms Won't Lower Costs

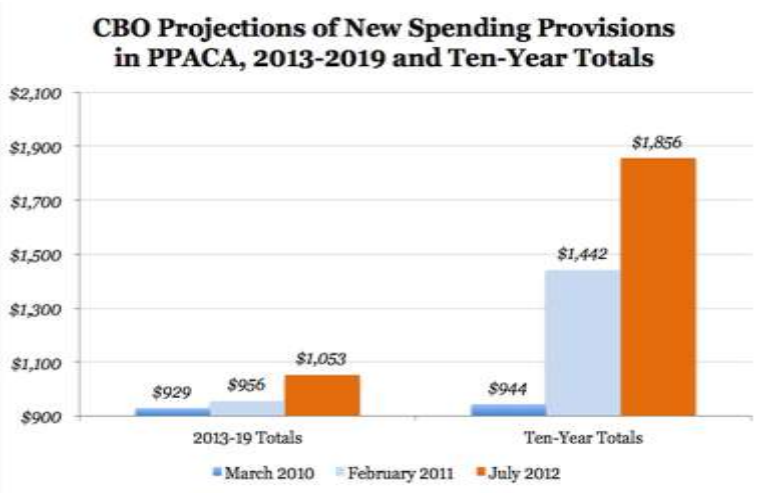
- Government-driven approaches to Medicare cost control have historically failed
- IPAB will lead to one-size-fits-all, government-driven rationing
- ACOs will increase provider consolidation, giving hospitals more market leverage to increase prices
- Lower provider payments will reduce retiree's access to care
- Reducing subsidies to Medicare Advantage will drive seniors out of that program

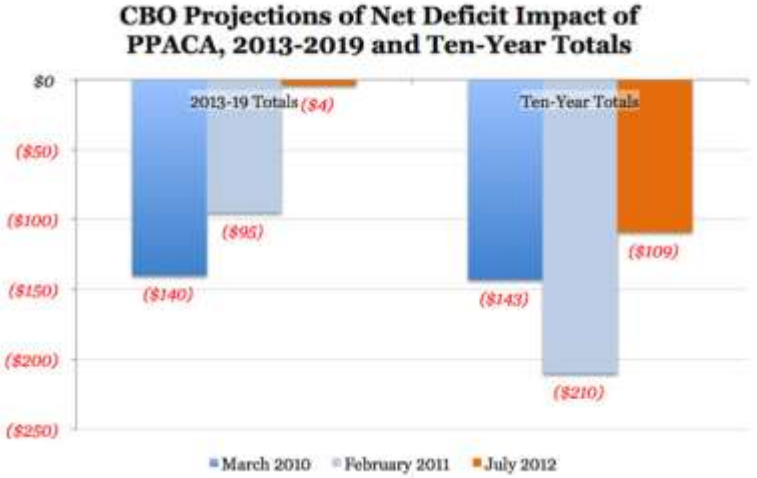
ACA Rolls Back Medicare Advantage

- According to the Centers for Medicare and Medicaid Services and the Heritage Foundation, by 2017, ACA Medicare Advantage cuts will:
  - Reduce the value of MA services in Washington state by $3,611 per year, relative to prior law
  - Reduce MA enrollment in Washington by 46%
- The market-oriented parts of the Medicare program (Part C & Part D) are the major drivers of slower Medicare spending growth, due to more efficient benefit management

Govt. Bean Counters Aren't Omniscient

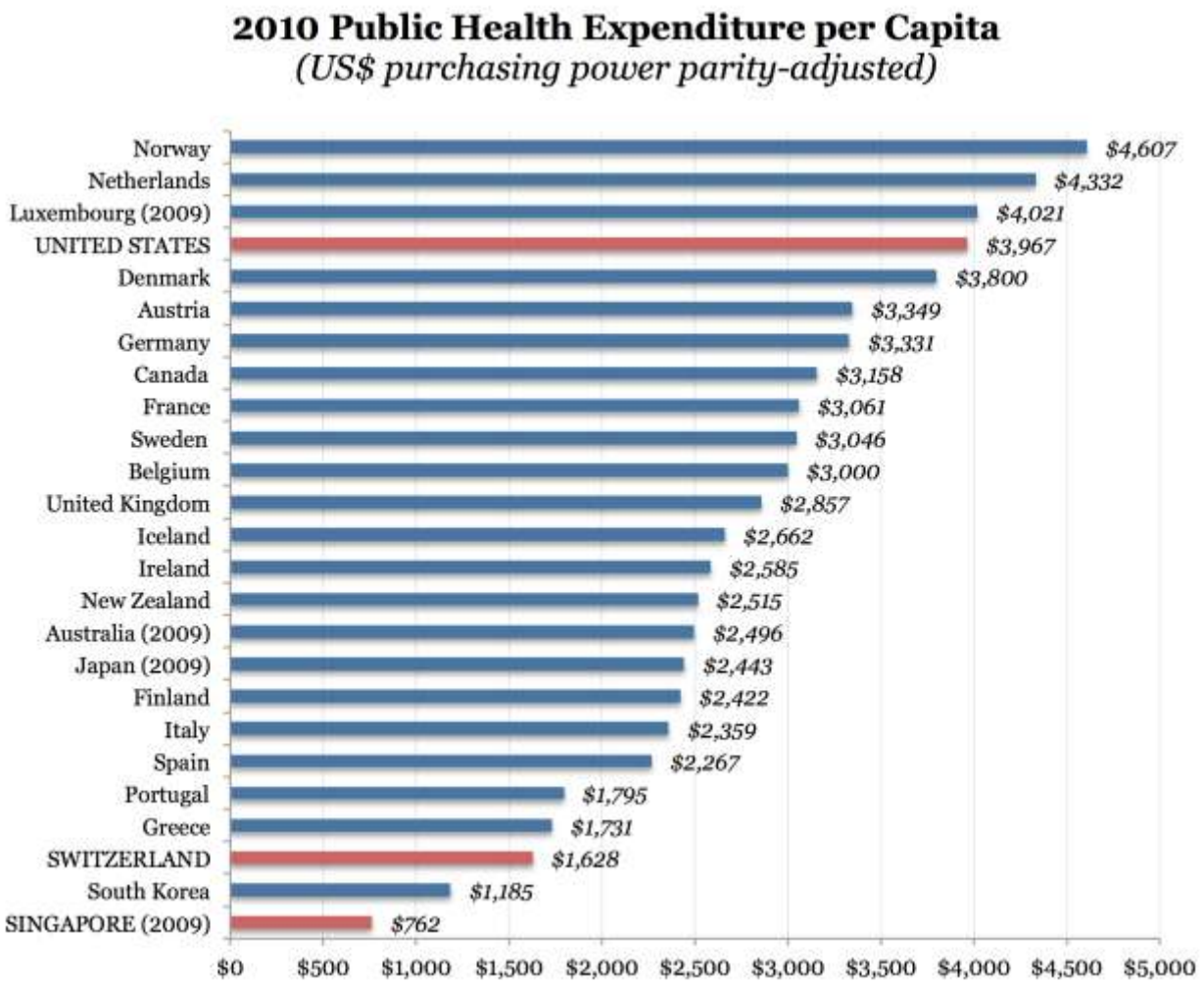
- While the CBO projects that the ACA is deficit neutral, gov't forecasts often underestimate spending and overestimate tax revenue
  - In 1965, Congress estimated that real Medicare spending in 1990 would be $12 billion
  - Actual 1990 spending was $110 billion
  - 2020 projected spending (CMS) is $1,047 billion
  - CBO only scores 10-year window





Is There A Better Way?

The Myth of 'Free-Market' U.S. Health Care



Source: OECD, WHO

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The Swiss Model for U.S. Health Reform

- Convergence of the ACA and Paul Ryan's reforms
  - ACA uses Swiss-style regulated insurance exchanges with a sliding scale of subsidies to offer coverage to those between 100% and 400% of the poverty line
  - Paul Ryan uses Swiss-style regulated insurance exchanges to offer coverage to future Medicare beneficiaries
- The ACA is an attractive mechanism for entitlement reform
  - Expand ACA exchanges to Medicare, Medicaid populations

Plan A: 'Repeal and Replace'

- Repeal Obamacare; replace it with a universal $2,500 tax credit for people to buy their own insurance
- Repeals Obamacare, block-grants Medicaid, applies Paul Ryan reforms to Medicare
- But, highly disruptive to existing insured
  - Repeals employer tax exclusion (155MM in 2016)
  - By 2016, CBO estimates 22 million on ACA exchanges, 12 million covered via Medicaid expansion
  - In 2012 there were 11 million Hispanic voters

Plan B: Swiss-Style Universal Exchanges

- **Learn from Singapore and Switzerland**
- Deregulate Obamacare exchanges to make them compatible with HSAs, catastrophic insurance
- Decrease Obamacare subsidy growth
- Repeal Obamacare taxes and mandates
- Gradually migrate entirety of Medicare and Medicaid onto reformed exchanges
- Would reduce more spending vs. repeal/replace
- Far less disruption to currently insured

Q & A

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Backup Slides

Privatization Has Slowed Medicare's Growth

- Laurence Baker (1999) showed a statistically significant correlation between Part C and reduced spending
  - Effect likely understated due to older data; lower HMO penetration
- CBO says Part D is biggest driver of slower Medicare growth
  - "The largest downward revision in the current baseline is for spending for…Part D (prescription drugs)." – 2013 *B&EO*

Table 3. Percent Changes in Medicare Fee-for-Service Expenditures Associated With Selected Representative Changes in System-wide HMO Market Share*

Changes in System-wide HMO Market Share	Part A	Part B
Moving from 10% to 20%	–2.0%	–1.5%
Moving from 20% to 30%	–2.5%	–1.6%
Moving from 30% to 40%	–3.0%	–1.6%

*Author's calculations based on regression results shown in Table 2. HMO indicates health maintenance organization.

—Baker LC. Association of managed care market share and health expenditures for fee-for-service Medicare patients. JAMA. *199;281:432-437.*

Remedies for Hospital Consolidation

- Increase market power of payors
  - Single-payer health care (pricing power, rationing)
  - Private insurance monopsonies
- Decrease market power of providers
  - Stronger and more effective antitrust action
  - Increase construction of new hospitals (certificate of need laws)
  - Facilitate medical tourism & telemedicine
- Price controls are a blunt and inefficient tool
- From both a political and policy perspective, *decreasing* provider market power is more attractive than *increasing* payor market power

Can There Be a Market for Health Care?

- Ken Arrow (Stanford) argued in 1963 that market forces cannot work in health care
  - People's demand for health care is **unpredictable**
  - Supply of medical services is limited by medical licensure, creating a **barrier to entry**
  - Medical services require **extreme trust**: medical error or malpractice can result in death or serious injury
  - Doctors know more about disease than patients, causing **asymmetries of information** that can be abused
  - Patients don't **pay for services directly**

Can There Be a Market for Health Care?

- It's not clear that Arrow's observations, however, are unique to health care
  - Health care is unpredictable, but so are many things (hence wide range of insurance products)
  - Licensure is now a widespread phenomenon
  - Extreme trust also required of pilots, car brakes, etc.
  - Asymmetries of information exist in many fields, but are decreasing due to the internet
  - Patients could pay for health care more directly than they do today **(but do we want them to?)**

Health Spending Keeps Going Up

Source: Congressional Budget Office